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THE COUNTY COUNCIL OF MIDDLESEX

ANNUAL REPORT

OF THE

SCHOOL MEDICAL OFFICER

FOR THE

YEAR 1923.

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Middlesex Education Committee.

REPORT OF THE SCHOOL MEDICAL OFFICER FOR THE YEAR 1923.

ELEMENTARY SCHOOLS.

Number of Schools and Children on the Rolls.

The Administrative County of Middlesex comprises 37 separate Sanitary Districts. In 24 of these the Middlesex County Council is the controlling authority for the purpose of Elementary Education. The Borough and District Councils are the Elementary Education Authorities in the remaining 13.

The 24 districts under the control of the County Council are set out in the following Table, together with the population, number of schools and number of children on the school registers on the 31st December, 1923, in each district.

Sanitary District.	Population.*	Number of Schools.	Total Number of Children on Rolls.
Urban—			
Brentford	17,520	8	2,800
Feltham	6,571	1	1,015
Friern Barnet	17,810	7	1,708
Greenford	1,458	1	120
Hampton	10,720	3	1,193
Hampton Wick	3,137	3	338
Hanwell	20,850	5	3,030
Harrow	19,640	4	2,003
Hayes	7,419	3	1,179
Kingsbury	1,971	1	239
Ruislip-Northwood	9,414	4	711
Southall-Norwood	31,360	8	4,481
Southgate	38,910	8	3,555
Staines	7,338	4	884
Sunbury	5,570	3	669
Teddington	21,500	6	2,703
Uxbridge	13,200	8	1,583
Wealdstone	13,750	3	1,829
Wembley	16,910	4	2,002
Yiewsley	5,272	3	870
Rural—			
Hendon	17,870	4	1,053
South Mimms	3,200	2	341
Staines	25,620	18	3,384
Uxbridge	11,190	8	1,753
	328,200	119	39,443

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* Registrar General's estimate of population, June, 1923, for purposes of vital statistics.

1. Staff.

School Medical Officer (also County Medical Officer of Health) ... ... Dr. J. Tate.

Deputy School Medical Officer (also Deputy County Medical Officer of Health) ... ... Dr. W. M. Ash.

Assistant School Medical Officers (also engaged in Maternity and Child Welfare work) :—

Dr. Alice Burn.
Dr. R. N. Daniel.
Dr. H. W. Moir.
Dr. H. L. W. Norrington.
Dr. A. R. H. Oakley.
Dr. Ruth E. Proctor.
Dr. Rachel H. Shelley.

Ophthalmic Surgeons (part time)—

Dr. Sophie G. Banham.
F. A. C. Tyrrell, Esq., F.R.C.S.

Senior Dental Officer ... ... Mr. S. J. Smith.

Dental Officers—

Miss F. M. Andrews.
Mrs. C. S. Leiper.
Mr. E. G. Parkinson.
1 vacant post.

School Nurses (also engaged as Health Visitors), 21.

Dental Nurses, 4 and 1 vacant post.

With the exception of the ophthalmic surgeons, all the above officers are employed whole-time by the County Council.

During the year Dr. C. W. F. Young, County Medical Officer of Health and School Medical Officer, resigned his appointment and I was appointed as his successor. Dr. Young had held the appointment of School Medical Officer since the commencement of school medical work in the County in 1908, and was responsible for the initiation, organisation and administration of the school medical service as it exists in Middlesex. It is a matter of deep regret that his health has not permitted him to continue to give to the County the very valuable services he has rendered in the past, and personally I desire to place on record my great indebtedness to him for the uniform courtesy and kindliness with which he has given me his advice and guidance during the whole period I have been his assistant and deputy. Dr. W. M. Ash was appointed Deputy County Medical Officer of Health on my promotion, and commenced his duties on the 13th August. Dr. Celia M. C. MacNeil left the staff of assistant medical officers at the end of July and the vacancy thus caused was filled by the appointment of Dr. Ruth E. Proctor. Mr. Wallace, one of the Council's Dental Officers, resigned his appointment toward the end of 1922 and was succeeded by Miss F. M. Andrews, who commenced her work with the Council in December, 1922.

2. Co-ordination.

There has been no alteration during 1923 in the arrangements for co-ordinating the work of the School Medical Service with that of other Health Services.

(*a*) *Maternity and child welfare.*—Under existing arrangements in the 14 sanitary districts in which the County Council is the authority for Maternity and Child Welfare, a child is under the care and supervision of the same officers from the time of birth till it leaves school. The County Council's Medical Officers are also responsible for the giving of antenatal advice, and every encouragement is given to expectant mothers to attend at the Welfare Centres. This advice is supplemented by supervision and assistance by the nurses at the homes if desired.

To a great extent the health of a school child is determined by the conditions at the home, by the care it has received during infancy and the first five years of life, and by the health of its mother during her pregnancy. By the amalgamation of the School and Maternity and Child Welfare Services all these determining factors are under the care and observation of the same officers who supervise the child's health when it is of school age.

(*b*) *Nursery Schools.*—These have not been provided in the Elementary School Area under the County Council.

(*c*) *Care of Debilitated Children under School Age.*—The Assistant School Medical Officers, as Medical Officers in charge of the Maternity and Child Welfare Centres, and the School Nurses, as Health Visitors, come into touch with debilitated and ailing children, and do much good by giving advice on feeding, etc., by detecting disease at its beginning and by advising parents to obtain medical aid where necessary. Assistance in finding out these children is also given by Attendance Officers, as described later under the heading "Co-operation of Parents, Teachers and Attendance Officers."

(*d*) *Tuberculosis Scheme.*—There continues to be close co-operation between the County Council's School Medical and Tuberculosis Medical Officers, whereby a school child found to be suffering from, or showing signs suggestive of, tuberculosis, is referred to one of the latter for diagnosis, observation and treatment if necessary.

(*e*) *Local Medical Officers of Health.*—As the officers primarily concerned with the control of infectious disease in their area, Local Medical Officers of Health receive the notifications of the occurrence of these diseases from medical practitioners. The County Medical Officer, however, in his capacity as School Medical Officer, has power to exclude individual children from any school under the authority of the County Education Committee, and to recommend the closure of such school, should he consider this course desirable on the grounds of Public Health. Co-operation with Local Medical Officers of Health is materially facilitated by the system of inter-notification between them and the County Medical Officer, Assistant Medical Officers and Head Teachers of Schools, which is in operation.

In the event of the condition of children attending school leading to the suspicion that the homes may be dirty or verminous, information is sent to the Local Medical Officer of Health who investigates the matter and takes any necessary action.

3. School Hygiene.

Owing to the rapid growth of the County, the majority of the schools in Middlesex are modern buildings, suitably situated and constructed, and with adequate sanitary, etc., arrangements. The general hygienic condition of the premises at each school is noted by the Assistant Medical Officers at the time of their routine visits. Any serious defects are reported to the Central Office in order that these may be referred to the Education Committee for such action as is necessary.

4. Medical Inspection.

The County Medical Officer, in his capacity as School Medical Officer, organises and supervises the work of the School Medical Service and is assisted by the Deputy County Medical Officer.

The Elementary School Area of the County is divided into seven districts, or areas, and in each of these areas one of the Assistant Medical Officers is in charge of the work of medical inspection and treatment, together with the supervision of Maternity and Child Welfare Work in such portion of the area as is under the administration of the County Council for this purpose. Each Assistant Medical Officer is in immediate supervision of the nurses allotted to the area, both in respect of their duties as School Nurses and Health Visitors.

So far as practicable, endeavour is made to visit each school for the purpose of routine medical inspection once each term. During 1923 this was only attainable in the case of 35 schools. Two visits were made to 32 schools, whilst time did not permit more than one routine inspection to be carried out in the remaining 52.

The two part-time Ophthalmic Surgeons carry out at the Clinics the refraction examination of children referred to them by the Assistant Medical Officers.

Dental inspections are made at the schools by the four whole-time dentists, assisted by the dental nurses. In the case of the districts of Harrow and Wealdstone, under the terms of the agreement with the Harrow Urban District Council, dental inspections at the schools are made by Miss Florence Goodman, L.D.S., who is engaged by the District Council at the Harrow and Wealdstone Joint Dental Clinic.

Systematic examination and re-examination of all children in the schools for the discovery of verminous conditions is carried out by the Nurses, and during 1923 an average of 14 such visits was paid to each school.

(*a*) *Age groups inspected* (*see* Table I, page 43).

Routine Medical Inspections.—All children falling into one of the following groups are inspected at the routine examinations in the schools, viz. : Entrants, Intermediates (*i.e.*, children between 8 and 9 years of age) and Leavers (*i.e.*, children of 12 years of age and upwards).

Special Inspections.—These are medical inspections by a Medical Officer of children specially referred to him by the Teachers, School Nurses, Attendance Officers, Parents, or otherwise, but not coming before him as one of an age-group for routine inspection. Such Special Inspections are carried out at schools or Clinics and occasionally at the children's homes.

Re-Inspections.—These are medical inspections of children who, as a result of a Routine or Special Inspection, come up later for subsequent re-inspection, either at the schools or Clinics.

(*b*) *Extent to which the Board's Schedule of Medical Inspection has been followed.*—All inspections have been carried out in accordance with the Schedule of the Board of Education.

(*c*) *Early Ascertainment of Crippling Defects.*—The steps taken to secure the early ascertainment of crippling defects consist of the special examination of children :—

(1) Under School Age, knowledge of whom has been gained through the Council's Maternity and Child Welfare Scheme.

(2) Attending the Tuberculosis Dispensaries of the County Council and reported by the Council's Tuberculosis Officers.

(3) Discovered by the School Nurses as result of their visits to homes.

(4) Reported by Head Teachers.

(5) Reported by Attendance Officers.

(6) Specially brought before the Assistant Medical Officers by parents.

(7) Reported by voluntary bodies and hospitals.

(8) Reported by School Medical Officers of other areas on removal into this County.

5. Findings of Medical Inspection.

The findings of Medical Inspection during 1923 are set out in tabular form in Tables II and IV, and their sub-sections. Table IIA shows the number of defects found. Table IIB shows the number of individual children having defects requiring treatment. No individual child is counted more than once in this part of the table, even if found to be suffering from more than one defect.

(*a*) *Uncleanliness.*—Table IV, Group V, affords detailed information as to the work of the school nurses in connection with the examinations made by them of children at the schools for the discovery of verminous conditions, etc. These examinations are made at surprise visits to the schools, so that children cannot be specially prepared for examination. The following is a comparative table showing the results of the examinations by the nurses for the past five years.

Year.	Number Inspected.	Number Found to be Uncleanly or Verminous.	Per cent.
1919	99,837	9,053	9·0
1920	126,521	12,118	9·5
1921	168,240	11,292	6·7
1922	160,591	10,972	6·8
1923	164,339	10,774	6·5

Although the figures for 1923 show a slight improvement in the County as a whole, the improvement was not uniform throughout the area. In one division of the County the relative number of verminous children has shown an increase, and on three occasions it has been found necessary to prosecute habitual offenders.

The prevalence of verminous conditions in school children depends upon two main factors :—

(1) School Environment.—The amount of attention paid by teachers to the general hygiene and cleanliness of children varies considerably, and is dependent on the degree to which the teacher appreciates the relation between physical fitness and mental progress. The condition of the school premises also is of importance. School premises should be kept scrupulously clean, adequate washing accommodation and a plentiful supply of soap and towels should be available in every school, not only as a hygienic measure, but as a part of the educational function of the school. The school children of to-day will become the householders of to-morrow, and the object lesson in cleanliness and hygiene, which schools should provide, ultimately will be reflected in a general improvement in the condition of the homes of the people.

(2) Home Environment.—Here the chief factor is the parents, especially the mother, on whom depend the cleanliness of the home and of the children. The condition of the house also needs to be taken into account. It is almost impossible to keep a dilapidated home reasonably clean, whilst it is well known that overcrowding is a potent factor in the spread of verminous conditions. The efforts of the School Medical Service are directed chiefly against the habitually verminous child. These children act as a continual source of infection to others at schools. As a rule they come from dirty homes and are the children of careless and dirty mothers. Fortunately this class is diminishing appreciably, but, so long as such cases exist, the efforts of the School Medical Service against verminous conditions must be maintained. Personal and family cleanliness should become general throughout the community, and the way to attain this end is through education in cleanliness and hygiene. It is the duty of all interested in education to see that the importance of cleanliness is taught in the schools with still more fervour in the future than in the past.

The rapidity with which lice (or pediculi) will multiply if unchecked is not sufficiently realised, and in this connection the following particulars may be of interest :—

Pediculi are the insects chiefly concerned with verminous conditions. There are two common varieties of pediculi, namely, the Head Louse (Pediculus Capitis) and the Body Louse (P. Corporis). The head louse resembles the body louse except that it is usually a little smaller and darker in colour. Although it is not common to find the former except on the head, it may spread all over the body.

Lice are small insects measuring about one-sixteenth of an inch when fully grown and varying in colour from light grey to almost black. They do not possess wings. They have six legs which are provided with claws, by means of which the insects clutch hairs and threads of clothing. They spend their whole life in close contact with the human body, on which they feed by first piercing the skin and then sucking the blood.

The female louse lays 100 to 120 eggs in the course of a fortnight; these eggs (or nits) hatch in 8 to 12 days as a rule, though it has been proved experimentally that an egg may hatch out any time up to five weeks from the date of laying. The young lice closely resemble the adults except that they are smaller, and almost immediately after hatching they commence to suck blood and continue to feed every few hours. They grow rapidly and at the end of a fortnight are sexually mature. The females of this brood now lay eggs which are in time hatched out, so that in the course of a few weeks one female may have thousands of descendants if favourable conditions are furnished by insufficient attention to cleanliness in person and clothing. Lice thrive best at the temperature usually existing amongst the clothes surrounding the human body, and under such conditions live as a rule for a month to six weeks. They do not, as once thought, quickly die if they become separated from their host, but may live for a week without access to food and at ordinary room temperature.

The eggs, or nits, are very resistant to ordinary disinfectants and can survive several days' exposure to frost. Those of the body louse are yellowish-white in colour, are attached to the fibres of clothing by a cement substance secreted by the female and are to be found chiefly in the seams and linings. They are goblet shaped and about the size of a small pinhead.

The head louse lays its eggs near the roots of the hair of the head. The newly-laid nits are opalescent, but as the larvæ inside develop they change to a yellowish colour. After hatching, the empty shells remain attached to the hair for a considerable time, but these are distinguishable from unhatched nits by their collapsed condition and brownish colour.

(*b*) *Minor Ailments.*—Under this category are included various skin conditions, minor eye and ear defects, minor injuries, etc., and full particulars as to these are set out in Table II. Reference to Table IV shows that a total of 9,213 such defects were in need of treatment and this total is much the same as the total for last year, viz., 9,500. Some reduction is to be noted in the number of cases of scabies which were observed, but otherwise no noticeable alteration in the occurrence of contagious skin disorders is revealed.

(*c*) *Tonsils and Adenoids.*—A total of 1,270 children, or 5 per cent. of the total number inspected, were found to be suffering from enlargement of the tonsils or adenoids or both. Of these 800 required treatment, which is equal to 3·1 per cent. of the number of children inspected as compared with 2·9 per cent. needing treatment in 1922.

(*d*) *Tuberculosis.*—In the course of medical inspection 76 cases of definite or suspected tuberculosis of all forms were reported during 1923. Of these 39 were Pulmonary and 37 Non-Pulmonary cases. All children, who were not already receiving treatment, were referred to the Council's Tuberculosis Medical Officers for expert opinion as to diagnosis and treatment. 45 children were so referred and of these 25 were found not to be suffering from tuberculosis. 10 Pulmonary cases and 4 Non-Pulmonary cases showed sufficient indication of disease to necessitate being kept under observation at the County Council's Tuberculosis Dispensaries, 3 were admitted to hospitals for surgical tuberculosis during the year, whilst 1 was awaiting admission to hospital, and 2 had failed to attend at the Dispensaries for examination at the close of the year. In addition to the 45 cases referred by the Assistant Medical Officers to the Tuberculosis Officers, 25 children of school age, living in the Elementary School area of the County, came to the notice of the Tuberculosis Officers in the course of their work under the County's Tuberculosis Scheme. Of these 1 was found not to be suffering from the disease, 4 Pulmonary and 1 Non-Pulmonary case showed sufficient signs of disease to require further observation, 8 cases were sent to Sanatorium and 9 cases to hospital, whilst at the end of the year, 2 cases were awaiting admission to hospital.

(*e*) *Skin Disease.*—See (*b*) minor ailments.

(*f*) *External Eye Disease.*—A total of 387 children or 1·5 per cent. were referred for treatment on account of blepharitis, whilst 6 others required to be kept under observation. The number of children having conjunctivitis was 168, of which 3 were kept under observation and not referred for treatment.

(*g*) *Vision.*—The number of children requiring treatment for defects of vision was 951 or 3·0 per cent., 107 others had defects of vision but were not in need of treatment. Squint was present in 160 children, of which number 86 were recommended to seek treatment.

(*h*) *Ear Disease and Hearing.*—Hearing was found to be defective in 273 children or 1·0 per cent., of whom 190 were in need of treatment for this condition. Otitis media was present in 634 cases or 2·5 per cent. These figures show a slight increase on the prevalence noted last year, whilst the proportion of other ear diseases noted remained practically unchanged, viz., 258 cases or 1·0 per cent.

(*i*) *Dental Defects.*—Reference to Table II shows that amongst 11,687 children examined by the Assistant Medical Officers at routine medical inspections 1,112, or 9·5 per cent., were found to have dental defects, of which number 1,036 were in need of treatment. These cases represent markedly defective teeth detected in the course of a general medical examination. In addition to these cases 625 children were brought up by Head Teachers for " special " examination on account of dental disease. More detailed examination by the dental staff reveals a very much higher proportion of dental defects, as is shown by Table IV, Group IV. Reference to this discloses the fact that out of 15,577 children examined 12,135, or 77·9 per cent., required treatment.

(*j*) *Crippling Defects.*—A total of 286 children suffering from varying degrees and types of deformity was noted during the year. From the fact that only 76 of these were in need of treatment, it is clear that the incidence of physical deformity of a serious nature is low in the area The figures for rickets illustrate this feature, for, whereas, careful examination led to the discovery of 97 children, who showed some trace of the presence of past or present rickets, only 9 children out of 25,423 examined had deformity due to rickets present in such a degree of severity as to indicate the need for active treatment. Although the social conditions of the inhabitants, combined with the physical characteristics of the Elementary School County, have a very considerable influence in the causation of the absence of rickets, there can be no doubt that the knowledge of infant feeding, care and management which is disseminated from the various Maternity and Child Welfare Centres in the area has assisted materially in bringing about this satisfactory result.

6. Infectious Disease.

Reference has been made to the co-operation which exists between the School Medical Staff and local Medical Officers of Health with regard to the control of infectious diseases occurring amongst school children. During 1923 many visits were made to schools by the Assistant School Medical Officers and local Medical Officers of Health, both jointly and separately, in order to detect early and " missed " cases and " carriers " of infectious disease. In this connection especial reference may be made to the energetic and efficient measures taken by Dr. Orr, Medical Officer of Health of Hanwell, to deal with diphtheria which was prevalent in the district of Hanwell during the latter part of the year. The work he undertook in connection with the schools was carried out in close co-operation with the school medical staff and was largely responsible for the ultimate control of the disease. For the assistance and guidance of Head Teachers the Education Committee have issued printed " Regulations as to Infectious Diseases " and the procedure laid down in these Regulations and described in the Annual Report of 1920, has been adhered to during the year.

School Closure.—No circumstances arose during 1923 which necessitated closure of any school in the area as a result of the occurrence of infectious disease.

EXCLUSIONS.—The number of children excluded from school during 1923 and the conditions for which they were excluded are set out in the following table :—

Cause.	By School Medical Officers, Tuberculosis Officers, and School Nurses.	By Medical Officers of Health.	By Teachers.
Infectious diseases—			
Chicken-pox	69	78	311
Contacts	1	69	37
Mumps	58	—	168
Contacts	—	—	7
Whooping cough	23	—	203
Contacts	—	—	33
Measles and suspected measles	2	—	197
Contacts	2	—	77
German measles	2	—	2
Contacts	—	—	1
Scarlet fever (cases or suspected cases)	33	276	—
Contacts	3	414	—
Diphtheria (cases or suspected cases)	18	163	—
Contacts	4	346	—
Typhoid (Enteric Fever)	—	3	—
Poliomyelitis contacts	—	1	1
Small pox contacts	2	—	—
Jaundice (including catarrhal Jaundice)	3	—	—
Contagious skin diseases—			
Ringworm	554	—	—
Impetigo	1,685	—	—
Scabies	221	—	—
Other skin diseases	2,059	—	—
Vermin	268	—	—
Enlarged glands (non-tubercular)	43	—	—
Tonsillitis (sore throat, &c.)....	200	—	1
Lungs (non-tubercular)	85	—	—
Phthisis (cases or suspected cases)	19	—	—
Other tuberculosis	12	—	—
Acute eye affections	64	—	—
Mental deficiency	12	—	—
Epilepsy (including suspected epilepsy)	7	—	—
Chorea	21	—	—
Heart disease	20	—	—
Accidents	40	—	—
Other conditions (including influenza)	260	—	—

7. Following-Up.

It has not been found necessary during 1923 to alter the existing arrangements for "following-up." These arrangements have been described in detail in previous Reports.

During the year the School Nurses made 2,143 visits to schools, 9,809 visits to the homes of children, and a total of 195,300 examinations and re-examinations of children for verminous and other conditions.

8. Medical Treatment.

(*a*) *Minor Ailments.*—The treatment of minor ailments is carried out at the School Clinics by the Assistant Medical Officers and Nurses. There are 19 Minor Ailments Clinics throughout the Education area under the County Council, and with two exceptions, namely Northwood and Sipson and Heathrow which are open once weekly, all clinics are open twice in each week.

The usual procedure is for the Assistant Medical Officer to attend each Clinic under his charge once during the week in order to advise and supervise treatment, whilst at the second opening, the Nurses continue the prescribed treatment.

The work carried out at the clinics is invaluable. Treatment being available for various inflammatory and contagious conditions at the earliest possible moment, cure can be effected within a reasonable time, and prolonged absence from school on account of sores, etc., is becoming almost unknown. This is clearly shown in the various reports of the Assistant Medical Officers. Dr. Burn, referring to skin conditions, reports :—

> "Much of the best work of the Treatment Clinics is done in these early skin cases. Quick detection by the teachers—immediate treatment (and possibly exclusion) secures a speedy cure and quick return to school. It is significant to note in this connection that the Treatment Clinics attendance records show a marked increase after a holiday period and a steady fall during a school term, to practically vanishing point at the end of the term."

And again referring to minor external diseases of the eye, she states—

> "Quite 60 per cent. are very mild inflammation, requiring only a few days' treatment. Again, everything in the nature of external eye defects is quickly referred for treatment, and there are practically no bad or chronic cases."

The following table gives information as to the addresses of the clinics for the Treatment of Minor Ailments now established in the area, together with particulars as to the days and hours at which these are open :—

Minor Ailment Clinics.	Attended by Medical Officer and Nurse.	Attended by Nurses only.
Council School, *Alperton*	9.30 Monday	2.30 Friday.
Woodthorpe Road School, *Ashford*	9.30 Thursday.	9.30 Monday.
Bramley House, The Butts, *Brentford.*	9.30 Monday.	9.30 Friday.
Council School, *Feltham*	9.30 Tuesday.	9.30 Friday.
Holly Park School, *Friern Barnet*	9.30 Monday.	2 Friday.
Greenford Avenue School, *Hanwell*	9.30 Thursday.	2.30 Monday.
Council School, *Harefield*	9.30 Thursday.	9.30 Monday.
Welldon Park School, *Harrow*	9.30 Tuesday.	9.30 Thursday.
Wesleyan Chapel Room, *Hayes*	9.30 Tuesday.	9.30 Friday.
Emmanuel Church Hall, *Northwood*	9.30 Wednesday (Alternate weeks).	9.30 Wednesday (Alternate weeks).
Council School, *Sipson and Heathrow*	9.30 Tuesday.	—
Beaconsfield Road School, *Southall*	9.30 Thursday.	9.30 Monday.
Highfield Road School, *Southgate*....	9.30 Tuesday.	9.30 Friday.
Kingston Road School, *Staines*	9.30 Wednesday	9.30 Friday.
139, Vicarage Road, *Sunbury*	9.30 Wednesday	2.30 Friday.
Stanley Road School, *Teddington*	9.30 Friday.	9.30 Tuesday.
Whitehall School, *Uxbridge*....	9.30 Tuesday.	2.30 Friday.
Bridge Infants' School, *Wealdstone*	9.30 Wednesday	9.30 Friday.
Providence Road School, *Yiewsley*	9.30 Friday.	9.30 Monday.

Detailed information as to the conditions dealt with at the Minor Ailment Clinics is set out on Table IV (Group I), but the following particulars are of interest :—

Number of Cases attending during 1923...	13,532
Number of Old Cases from 1922 attending during 1923	494
Total attendances made by the above children	48,645
Number of Children under treatment on 31st December, 1923	447

(*b*) *Tonsils and Adenoids.*—There are no special arrangements for the treatment of these conditions. Cases requiring special forms of treatment are referred to their private medical practitioners or to hospitals where such treatment, operative or otherwise, is carried out.

With regard to cases referred for observation, Dr. Burn reports :—

> "All are advised at the first inspection in methods of nasal hygiene and throat disinfection. Combined with the school drill along the same lines, and an improved parental conscience in the matter of breathing habits, post-nasal and pharyngeal conditions are showing marked improvements."

Dr. Burn states that the results found, after a period of observation during which time the above procedure was carried out, are as follows :—

> "Of the 109 observation cases, quite 50 per cent. have since been 'written off' as not requiring any form of treatment."

(*c*) *Tuberculosis.*—The treatment of tuberculosis in school children is amply provided for by the County Council's scheme for the treatment of tuberculosis, details of which have been given in previous Annual Reports.

All cases in which the suspicion of tuberculosis exists are kept under observation by the Council's Tuberculosis Medical Officers at the various dispensaries in the County. Children suffering from Pulmonary Tuberculosis, and in need of institutional treatment, are admitted to the Council's Sanatorium at Harefield.

This institution provides accommodation for the treatment of 56 children and has eight additional beds, or cots, reserved for children requiring observation under institutional conditions. The whole of the accommodation for children is contained in a separate pavilion in the sanatorium grounds, and a special sanatorium school, approved by the Board of Education, with a staff of two resident teachers has also been provided for the use of the children. Children suffering from surgical forms of tuberculosis or advanced pulmonary disease are sent by the County Council to other institutions approved by the Ministry of Health but not directly under the control of the County Council. The majority of the cases of bone and joint tuberculosis are sent to the Royal Sea Bathing Hospital, Margate; Lord Mayor Treloar's Home, Alton; the Victoria Home, Margate; and the Alexandra Hospital for Children with Hip Disease, Clandon.

Statistical details of cases of school children residing in the Elementary Education area of the County and treated in institutions under the Middlesex County Council's Tuberculosis Scheme during 1923 are shown in the following tables. Some of these cases were admitted prior to the 1st January, 1923, but were remaining in on and after that date. These therefore do not appear in Table IIa. Again, only those remaining in on the 31st December, 1923, appear in Table III.

	Pulmonary Cases.		Surgical cases.	Total.
	Sanatorium.	Hospital.		
In Institutions on 1st January, 1923	13	3	20	36
Admitted to Institutions during 1923	14	3	24	41
Totals	27	6	44	77
Discharged—Disease arrested, quiescent, or greatly improved	11	—	13	24
Discharged—Disease improved....	2	1	7	10
Discharged—Disease not improved	2	—	—	2
Died in Institution or shortly after discharge....	2	4	—	6
Disease found not to be tubercular	2	—	—	2
Remaining in Institutions at end of 1923	8	1	24	33
Totals	27	6	44	77

(*d*) *and* (*e*) *Skin Disease and External Eye Disease.*—*See* (*a*) Minor Ailments.

(*f*) *Vision.*—The treatment of cases of defective vision is carried out by the Council's Ophthalmic Surgeons at six Ophthalmic Treatment Clinics in the area. Weekly sessions are held at each, unless the number of cases referred for treatment by the Assistant Medical Officers is insufficient to render this necessary. The addresses of the clinics and the days and times at which sessions are held are as follows :—

Bramley House, The Butts, *Brentford.*—9.30, Thursday, Dr. Banham.
Council School, *Feltham.*—10 a.m., Wednesday, Dr. Banham.
Beaconsfield Road School, *Southall.*—9.30, Wednesday, Mr. Tyrrell.
Garfield Road School, *Southgate.*—2 p.m., Thursday, Mr. Tyrrell.
Bridge School, *Wealdstone.*—2 p.m., Tuesday, Mr. Tyrrell.
Providence Road School, *Yiewsley.*—9.30, Tuesday, Dr. Banham.

In connection with the work at the Ophthalmic Clinics (*see* Table IV), it may be mentioned that during 1922 the Committee decided that the nurses in attendance should undertake at the clinics the collection of fees payable for the treatment of visual defects. This system still obtains, and, in the event of failure to obtain the required fee, particulars are forwarded to the Education Committee, who investigate the circumstances of the family and arrange for the collection of the fee by the Attendance Officers, except in cases of necessity.

Dr. Banham, in reporting on the work of the year at her centres, states :—

> The parents show increased interest in the work done and in many cases, on their own initiative, the children have been brought for re-inspection and also for advice as to suitable employment, with reference to their eyes, on leaving school. The regular work of refraction and prescribing of glasses has been carried on and old cases are seen again at least every second year.

> An effort is made to see all the cases of myopia on the books once during each year. A note with regard to restriction of close work is sent to the school in those cases requiring special care in the method of teaching and several cases of progressive myopia have been recommended for education in a special school. Other cases recommended for teaching in a school for the blind, include congenital cataract, retinitis pigmentosa and severe nebulous corneæ.

Mr. Tyrrell, in addition to noting some cases of special interest, calls attention to the desirability of the establishment of a special class for myopic children in the district of New Southgate. He writes :—

> "There are some dozen children attending schools in the New Southgate area, for whom it is hoped that a special class for education will be formed. These are mostly cases of progressive high myopia, requiring oral teaching and special instruction by a suitably trained teacher.
>
> Among the cases attending the clinics were several children with night blindness. The cases were examples of degenerative retinitis without pigmentation, but with early optic atrophy. They were kept under observation for some time and are now having home teaching in Braille. An unusual case attending the Wealdstone Clinic was that of a child with persistent bleeding from the right eye, accompanied by spasmodic ptosis and nystagmus. No wound could be discovered on any part of the palpebral or ocular conjunctiva. Yet the pad on her eye was always soaked in blood. The bleeding was undoubtedly produced voluntarily by some means or other, the symptoms being all characteristic of advanced neurosis unusual at an early age."

(*g*) *Ear Disease and hearing.*—A total of 908 children received treatment for minor ear defects at the clinics for the treatment of minor ailments.

(*h*) *Dental defects.*—The treatment of dental defects is carried out by the four whole-time dentists on the Council's staff and, in addition, children attending schools in the districts of Harrow and Wealdstone are dealt with by Miss Goodman, the Dental Officer of the Harrow and Wealdstone Joint Dental Clinic. (Particulars of the arrangements with regard to the districts of Harrow and Wealdstone have been given in previous reports.) In the case of remote schools the dentists carry out treatment at the schools, but otherwise children are dealt with at one or other of the following eight Dental Clinics :—

Council School, *Alperton.* Mr. Parkinson.
Bramley House, *Brentford.* Mrs. Leiper.
Holly Park School, *Friern Barnet.* Mrs. Leiper.
Beaconsfield Road School, *Southall.* Mr. Smith.
Friends' Meeting House, *Staines.* Miss Andrews.
Stanley Road School, *Teddington.* Miss Andrews.
Whitehall School, *Uxbridge.* Mr. Parkinson.
Harrow and Wealdstone Joint Dental Clinic, *Harrow.* Miss Goodman.

Statistical details of the dental work carried out during the year are set out on Table IV. Similar arrangements exist with regard to the collection of fees for dental treatment as obtain in the case of ophthalmic treatment. The reports of the dental officers reveal that there is still a considerable amount of ignorance and prejudice to be overcome before some parents are willing to have early conservative dental treatment given to their children. That the systematic work now being carried out in the County ultimately will prove to the parents the value of dental treatment is indicated by the experience of Mrs. Leiper in the district of Friern Barnet (*see* below). The educational talks undertaken by Mr. Smith, Senior Dental Officer, also should prove of benefit in this direction.

Reporting on the work in his area, Mr. Smith writes :—

> "Many parents refuse the filling of the first permanent molar on the ground that it is a temporary tooth ; others prefer to wait till the tooth aches. Some parents, again, object to temporary teeth being removed, giving as their reason that these will drop out of their own accord."

In addition to the advice given individually to mothers attending with their children at the Clinics, Mr. Smith has continued to give short collective addresses at the schools to mothers, teachers, and children, when this can conveniently be arranged. Nine such lectures were given in 1923 and were much appreciated. Mr. Smith states :—

> "My scheme has been to give a short and simple lecture in homely language, illustrated by diagrams, describing the structure and use of the various teeth, the two dentitions, and their

> bearing on one another, pointing out the foods which are detrimental and which cause decay, and recommending the foods which would be least harmful. I also give instructions in the use of the toothbrush and am emphatic about the use of it at least twice a day."

Mrs. Leiper, reporting on the work in her area, writes :—

> " In the Friern Barnet district, where my clinic has been established for several years, the early prejudice against conservative treatment has almost entirely disappeared, and the number of cases in which consent is volunteered is now sufficient to keep the clinic in full work without special effort having to be made to secure 'consents,' and it is now a common and agreeable experience to hear the commendatory expressions regarding the provision by the Authority of School Dental Clinics."

Mr. Parkinson, commenting on the cases in which refusal to sanction treatment is experienced, says :—

> " These were due to ignorance and apathy on the part of parents, the ignorance especially applying to the first permanent molar, which, in the majority of cases, is thought to be a temporary tooth."

He points out that where parents attend at the inspections the refusals are very much fewer, for the necessity for treatment is explained to them by demonstrating the actual condition of the child's mouth.

> " I have been struck by the healthy mouths of those children, who were treated after the first inspection. Where treatment was necessary, in the majority of cases only small cavities required filling, whilst in many cases caries had been completely arrested, and many parents spoke of the better health of their children following treatment. This result is very encouraging, and it augurs well for the scheme when all the age-groups can be included as routine cases. I have not noticed any difference from the last two years in the mouths of the five-year old age-group admitted during the year. Invariably the 'refusals' of the two previous years were much worse."

Miss Andrews similarly calls attention to the beneficial results attending conservative dental treatment. She reports :—

> " Amongst those who have had treatment for two years consecutively very good results have been noted, and little or no treatment was necessary at their third inspection."

(*i*) *Crippling Defects and Orthopædics.*—There are no special arrangements for the treatment of orthopædic cases. In view of the absence of any considerable number of cases of rickets of marked degree, the fact that the County Council's scheme for the treatment of tuberculosis deals with children suffering from surgical tuberculosis, and the proximity of Middlesex to the special and general hospitals in London, special provision by the Education Committee for dealing with crippling defects does not appear to be a matter of urgency.

9. Open-Air Education.

In many of the schools classes are held in the playground during the summer months.

Provision has also been made for the accommodation of children suffering from mal-nutrition, wasting, anæmia, debility, other illness, etc., at convalescent homes. During the year children have been sent to the—

Ogilvie School of Recovery, Clacton.
Brooklyn Convalescent Home, Worthing.
Edgar Lee Convalescent Home, Stonebridge Park.
The Convalescent Home, Seaford, etc.

Number of children—

In Convalescent Homes on 1st January, 1923 ...	6
Admitted to Convalescent Homes during 1923 ...	8
Discharged from Convalescent Homes during 1923	5
Still in Convalescent Homes on 31st December, 1923	9

In addition, the King Edward VII Memorial Convalescent Home, Herne Bay, admits a number of children for periods of 14 days each on the recommendation of the school teachers.

10. Physical Training.

The supervision of physical training is included in the duties of the Assistant Medical Officers. At their visits to the schools, the latter see the childern at their exercises and discuss with the teachers the aims and objects of physical training. Physical training is not limited to formal drill and exercises, but embraces every form of activity which goes to promote a healthy mode of life, and can be taken part in by groups of children under supervision. It follows that dancing, swimming, gardening, games, etc., are all forms of physical training, each with its own special value. The Assistant Medical Officers render assistance to the teachers, not only by giving advice on the general question of physical training, but in calling attention to special cases of ailing children where such training needs to be modified.

11. Provision of Meals.

There has not been any necessity during 1923 to take action under the Provision of Meals Acts, 1906-14.

12. School Baths.

There is nothing to add to the report of 1920.

13. Co-operation of Parents.

A written notice is sent to all parents two days before the examination of their children is due. In order to avoid inconvenience, information as to the hour at which the examination is to take place is mentioned on the notice, and, as in the past, the great majority of parents have availed themselves of the invitation to be present.

14. Co-operation of Teachers.

Since the commencement of school medical work in the County, the teachers have rendered most valuable assistance ungrudgingly and with enthusiasm, and much of the success which has attended the work of inspection and treatment is due to their efforts. Their assistance includes the sending of notifications to parents, taking and recording heights and weights, attending with the medical officers at the time of inspection, notifying to the School Medical Officer and Local Medical Officers of Health absences due to suspected infectious or contagious diseases, selecting and presenting for examination "Special" and "Ailing" children, and not least using their influence to urge careless parents to avail themselves of the facilities for treatment provided by the Education Committee.

15. Co-operation of Attendance Officers.

The assistance given by Attendance Officers is greatly appreciated. They have done valuable work in bringing, for medical examination, children whose attendance has been unsatisfactory through ill-health, and in bringing to the notice of the Medical Officer cases of physically or mentally defective children who have not yet attended at school on account of their defect. The collection of fees for ophthalmic and dental treatment, in cases where these have not been paid to the nurses at the clinics, is another of the many ways in which they render assistance to the School Medical Service.

16. Co-operation of Voluntary Bodies.

No recognised scheme for co-operation with voluntary bodies exists. In one or two districts, however, local School Managers are assisted in obtaining hospital letters, etc., by Care Committees and Guilds of Help. On several occasions cases of apparent cruelty and neglect have been referred to the local Inspectors of the Society for the Prevention of Cruelty to Children, and in each instance assistance has readily been given.

17. Blind, Deaf, Defective and Epileptic Children.

Full statistical details as to these children are set out in Table III. Under Part V of the Education Act, 1921, it is the duty of the local Education Authority to make suitable provision for the efficient education of Blind, Deaf, Defective and Epileptic Children. In accordance with Section 53 of the Act, Head Teachers, School Attendance Officers, and School Nurses are under instruction to report for medical examination any children who appear to be physically defective or epileptic. All such cases are examined in detail by the Assistant Medical Officers and reported to the Education Committee with a view to admission to suitable special schools, if necessary. In this connection attention may be drawn to the great difficulty experienced in obtaining vacancies for children suffering from severe heart disease or from a combination of defects, any one of which, alone, would render the child suitable for admission to an approved Residential School.

In last year's report account was given of a special class for dull and backward children held in Bowes Road Council School, Southgate. Dr. Daniel has continued to keep the children under observation, and has submitted a detailed report on their progress. From this it appears that, with one exception, all have made varying degrees of progress, but none sufficient to justify their transference to the ordinary school classes. Dr. Daniel adds :—

> "The special class cannot, without prejudice to its value, retain boys and girls of any age ; it would soon become too large for the teacher to give that individual attention which is of the first importance. Were it possible to arrange for a Special Class in the 'Boys' Department' and in the 'Girls' Department,' such classes could receive children from the Special Class in the 'Infants' Department,' thus securing continuity in the work of educating them."

18. Nursery Schools.

No such schools exist in the area.

19 & 20. Secondary and Continuation Schools.

Area and Number of Schools.—The whole of the Administrative County of Middlesex is under the County Council for the purpose of Secondary Education. There are 35 Secondary Schools in the Area, 13 Boys' Schools, 10 Girls' School, and 12 Mixed Schools. In addition to these there are 6 Trade Schools, 3 for Boys and 3 for Girls.

The Arrangements for Medical Inspection.—A full report on the arrangements made for medical inspection of pupils in Secondary Schools is set out in the Annual Reports of 1920 and 1922.

Findings of Medical Inspection.—Full statistical details of defects found amongst pupils of secondary schools, day continuation and trade schools are given in Tables on pages 57 et seq.

Following up.—At the conclusion of medical inspection, a list of children found to be suffering from defects and in need of treatment is left with the Head Teacher of the

School. This enables the Head Teachers to use their influence with pupils and parents with a view to treatment being obtained. After the expiration of a month, these lists are returned to the medical inspector with a note as to the action which has been taken by the parents to have the defect remedied. On the occasion of the next visit to the school by the medical inspector, all pupils previously found to be suffering from various defects are re-examined and a further note sent to the parents if the condition appears at all serious or progressive.

Medical Treatment.—No arrangements have been made for treating defects discovered in pupils attending Secondary, Day Continuation and Trade Schools. It is found that in the majority of cases parents take their child to their private doctor for treatment. Defects requiring particular physical exercises for their rectification are pointed out to the Physical Instructor of the School for his guidance. Special attention is drawn to a report by Dr. Daniel on the importance of the teaching of swimming at secondary schools (*see* page 39).

21. Employment of Children and Young Persons.

The total number of children medically examined for employment certificates during 1923 was 1,027, of whom 14 were rejected as unsuitable and were refused certification.

No case has been reported in which the employment has proved to be detrimental to the child's health. Two children were medically examined, prior to the issuing of licences, to enable them to take part in entertainments.

22. Special Inquiries.

(*a*) SPEECH DEFECTS IN ELEMENTARY SCHOOL CHILDREN.

Speech defects in school children, though not very common, occur with sufficient frequency to justify special inquiry into the condition. Whilst the total number of children affected may not be large, it is only necessary to recall the marked mental distress which is occasioned to the individual child affected and the grave disability experienced in adult life to realise the importance of the subject, especially having in mind the fact that a large proportion of the cases are capable of prevention, amelioration or cure, if adequately treated in childhood. In this connection attention may be drawn to the necessity of instilling into the minds of those who have the care of children with speech defects the fallacy of the "grow out of it" dictum, and the need for discouraging "baby talk" as the children grow older.

During 1923 the question of the prevalence of various defects of speech amongst the children attending the Elementary Schools in Middlesex was made the subject of special inquiry by all the Assistant School Medical Officers, and the Head Teachers were asked to assist by bringing forward as "Specials" any children known to them as suffering from defective speech. The results of the inquiry reveal the presence of 301 cases of speech defect in the Elementary Schools, and, whilst this figure cannot be taken as including all cases existing in the Area, it is reasonable to assume it includes a large proportion of such cases.

A brief description of the commoner defects of speech is given below, together with information as to the number of cases in each group noted in the Area.

I. *Speech Defects due to errors of control of the speech-producing apparatus.*

(*a*) *Lisping.*—This defect is due to the imperfect pronunciation of certain consonants or the actual replacement of these by others. Thus S becomes Th ; R becomes W or Y ; Th becomes S or F ; K becomes T, G or D, &c.

The common causes of the condition are :—

(i) Persistence of the pronunciation of babyhood.
(ii) Early loss of front teeth.
(iii) Malformation of the mouth, particularly if such should cause a backward displacement of the upper front teeth.
(iv) Imitation.

The prospect of cure in cases of lisping is good.

(*b*) *Lalling.*—This is a more marked persistence of baby speech. In addition to difficulty in pronouncing consonants, the oral speech mechanism is badly under control, resulting in the slurring of words or syllables, and speech may be very indistinct. Frequently the child has one special consonant which it uses whenever possible.

The defect is common in mentally defectives, and in them it is likely to persist throughout life.

(*c*) *Idioglossia.*—This is an exaggeration of lalling. The speech is fluent, thus differing from the "lalling" of mentally defectives; but difficult consonants, or even words, are so freely replaced by easy ones, and articulation is so defective, that speech is almost unintelligible until carefully analysed.

Dr. L. H. F. Thatcher gives the following typical example of this condition. It is the Lord's Prayer as said by a case of idioglossia:—

> "Ouë Tahde na ah in edde, anno de di na, I tidde tah, I du de di on eet a te e edde, &c."

The condition is probably cerebral in origin, but the outlook is good if care be taken to exclude cases of mental deficiency.

Of the 301 cases of defective speech noted in the County Area, 127 (42·2 per cent.) were cases of lisping or lalling.

II. *Speech Defects due to errors of co-ordination of the speech-producing apparatus.*

(*a*) *Stammering and Stuttering.*—The term "Stammering," now generally used to include "Stuttering," should be confined to those cases in which there is difficulty in commencing a word or sudden cessation in the middle of a word, due to spasm of the speech muscles; whilst "Stuttering" should be applied to those cases in which there is a rapid machine-gun-like repetition of a consonantal sound, owing to the difficulty of getting on to the vowel.

The condition is frequently indicative of an unstable nervous system, and in such cases other signs of instability of the nervous system may be evident, such as night-terrors, nocturnal enuresis, &c. Stammering usually begins after a child has learnt to speak fluently, and frequently the onset of stammering coincides with the cutting of the permanent teeth. Often there is some direct cause, such as a fright or illness. Imitation is considered by some to be an important factor, particularly where several cases occur in the family, whilst heredity seems to have little influence. Adenoids are frequently found in association with stammering, but they probably act as a focus of peripheral stimulation, just as do phimosis, cutting of teeth, and intestinal worms. No evidence of change in the nervous system or in the organs of speech has been found to account for the defect.

Although stammering usually comes on after a child has developed fluent speech, it may appear (i) before this, when, as a rule, it is quite a temporary phenomenon, being accentuated by the emotions, notably fear or violent temper, or (ii) during adult life, when it is associated with organic disease of the brain.

Stammering and stuttering are rare in the mentally defective, and stammerers are frequently above the average standard of intelligence.

(*b*) *Apthongia.*—Another spasmodic affection of speech, due to spasm of the muscles of the tongue on attempting to speak.

(*c*) *Bradylalia.*—Characterised by marked slowness of speech.

(*d*) *Echolalia.*—A repetition by the child of what is said to him ; this occurs most frequently in imbeciles.

Stammering and stuttering accounted for 123 cases of speech defect (or 40·9 per cent. of the total). Of these cases the proportion of boys to girls was as 6 to 1, which is rather higher than the proportion usually observed, viz., 4 or 5 to 1, but as the total number of cases was small this discrepancy is not remarkable.

III. *Speech Defects due to physical defects of the speech-producing apparatus.*

The character of the speech in this group of cases differs according to the nature of the underlying physical cause. All may be classified as instances of " indistinct " speech.

The following physical defects are examples of conditions producing " indistinct " speech :—

(i) *Tongue-tie.*—This is a rare condition, though it is frequently blamed by mothers. No tongue-tie is present if a child can put the tip of his tongue out beyond the lower lip, nor is there tongue-tie if the child can pronounce clearly any word beginning with L.

(ii) " *Cold in the head.*"—This complaint interferes with nasal resonance and causes a well-known defect of speech. A chronic variety of this form of defect is produced by *adenoids and enlarged tonsils.*

(iii) *Deficiency of the roof of the mouth.*—This defect may be congenital cleft palate, or acquired perforation of the palate.

Cleft palate.—The roof of the mouth is formed by the fusion of three bones. These bones should join together before birth, but occasionally fusion fails to take place, with the result that the child is born with cleft palate. Not infrequently the upper lip also is mal-developed, giving rise to a condition known as " hare-lip." The defective roof of the mouth throws the nasal and buccal cavities into one, so that it is impossible to shut off the buccal cavity from the outside air.

A person with a cleft palate, therefore, is unable either to raise or lower the air pressure in his mouth above that of the outside air. *The inability to lower* the pressure makes it impossible for a child to suck, and consequently difficulty arises in the administration of sufficient nourishment. If this early stage of infant life is survived, the next difficulty comes with the effort to speak. *The inability to raise* the air pressure in the mouth prevents the formation of all letters known as " explosives," *e.g.*, dentals (d.t.), labials (b.p.) and gutturals (g.f.).

(iv) *Deafness.*—If a child has never heard speech it will not be able to speak itself, unless taught by special methods. If absolute deafness comes on soon after a child has learnt to speak, the faculty of speech will gradually be lost. Such children, therefore, become deaf mutes.

Partial deafness produces a careless, slurring way of speaking, because words are not properly heard, and when reproduced are slurred over.

Fifty-one examples of " indistinct speech " were noted, of which 7 (or 2·0 per cent. of total defects found) were due to cleft palate, and 44 (or 14·6 per cent.) due to other causes, chiefly " colds " and adenoids.

The importance of early and adequate treatment in the case of the more serious defects of speech is discussed at some length by Dr. Daniel, and as the information obtained by him with regard to the children in his Area suffering from defects of speech is of considerable interest, his Report is given below.

DR. DANIEL'S REPORT ON SPEECH DEFECTS IN HIS AREA.

During 1923 the Head Teachers of the Schools in the Public Elementary Schools in Area I were asked to make returns of all children observed by them, or by the Assistant Teachers, as having, or possibly having, any defect of speech. The returns gave a total of 111 children, and of these 97 were found to have some defect of speech. As all defects, whatever the character or degree, might be remedied or improved by training, no case with any defect was regarded as not requiring treatment.

The number of children in the Area on the School attendance rolls for 1923 was 5,604, and of these 97 had some speech defect, a percentage of 1·7. The findings are given in the following table :—

——	Boys.	Girls.	Per Cent.
Stammer Stutter	31	6	0·66
Lisp	21	13	0·60
Indistinct	15	7	0·39
Cleft palate	—	4	0·07
	67	30	1·73

As there seems to be no practical advantage in classifying the stammerers and stutterers separately, they are grouped together. Both defects were often found combined. But it may be mentioned that of the 31 boys in this group, with 23 stammering was more in evidence, with 8 stuttering prevailed. In the case of the 6 girls, 3 were more definitely stammerers and 3 more definitely stutterers.

Really reliable information as to the child's age when speech defect was first noticed is almost always difficult, and often impossible to obtain. In this connection the statements of parents are, perhaps, apt to be influenced by "the wish being father to the thought." Sometimes one is told that there was "nothing wrong till the child went to school," or "we never hear anything of it at home." It has, however, been found not infrequently that parents overlook defects in other directions, *e.g.*, slight degree of squint, torticollis, muscle wasting, limp, flatfoot, lateral curvature of the spine, &c. ; therefore it is quite likely that many slight speech defects are really not noticed by parents until their attention has been drawn to them.

Stammering (including Stuttering).

31 boys, 6 girls.

Etiology and associated conditions.—With regard to 11 boys and 2 girls a history was obtained of speech defect in the family. In 3 families the mother stammered, in 3 the father ; and in 4 families an elder brother stammered, in 3 an elder sister. It is not improbable, therefore, that some of these 13 boys and girls were originally "imitative" stammerers. It seems reasonable to assume that heredity may be a factor, but it would be difficult to say what exactly is inherited. An imitation stammer might be acquired not in the family but at School.

One boy, aged 8, was reported not to have stammered till after an attack of whooping cough when he was 7. Another boy, aged 11, had a fractured humerus when 6, and his stammer is said to date from the time of the accident. One boy was left handed.

8·1 per cent. of the stammerers had some obstruction in the upper air passages, as compared with 6·9 per cent. of the 4,542 children examined at routine inspections and at the clinics who were similarly affected.

16·2 per cent. of the stammerers had some defect of vision, including squint, the percentage of defective vision among the 4,542 children examined being 6·4.

Faulty control of respiration was found in all the stammering children, and whatever view may be held about the part that faulty respiratory control plays, whether as a primary cause or merely an associated condition, there can be no doubt at all about its prevalence and the necessity of paying very special attention to it in dealing with stammerers.

None of the stammerers suffered from defective hearing, and of 181 children seen during 1923 with minor ear defects none was found to stammer. The same applies to the children seen with slight or moderate chorea, of which there were 12. No child was found to be tongue-tied.

However desirable it may be, as undoubtedly it is, to remedy *any* physical defect found in a stammering child, it was not found that physical defects played a very distinctive rôle among these children, except perhaps that of defective vision.

Contortions which cannot be concealed cause much distress to many adult stammerers, and no doubt to children also. Of such spasmodic movements those of the face muscles only were most frequently found.

—	Boys.	Girls.
Irregular movements of face muscles only	25	3
Irregular movements of face and neck muscles	1	1
Irregular movements of face, neck and limb muscles	2	—

The dumb stammerers are an interesting group. Such children when addressed will stand motionless and voiceless. They seem to require some kind of mental kick to set the speech mechanism going, as some drunk people require a push off before they can start walking. Three boys and two girls were found to be affected with this condition.

Age when examined.—Of the 37 stammerers, 28, or 75·6 per cent., were between the 9th and 14th year inclusive, *i.e.*, children in the second half of their school life.

It is, of course, well known that stammering is much commoner among boys than girls, and amongst the 37 cases noted the boys have a percentage of 83·7. Why they are so much more frequently victims of this defect than girls is obscure. Whatever part physical defects may play as aggravating existing stammer, and if neglected hindering cure, that they are really ever exciting causes seems improbable. Physical defects, such as obstruction in the upper air passages, spinal irregularities, &c., are common enough among girls, especially the last-named ; and if such physical defects are exciting causes of stammer, as some think, one would certainly not expect to find so great a difference between the number of boy stammerers and girl stammerers.

Indistinct Speech.

Of the 22 cases, 15 were boys and 7 girls, and 68·1 per cent. of the cases were between the 7th and 9th years inclusive. It will, of course, be understood that the ages given were the ages at the time of the examination, not the ages when the defect was first noticed. At least 3 of the boys and 2 of the girls have never spoken distinctly. The 2 girls were partial deaf mutes ; the three boys were late in speaking—2 did not speak till the 4th year, and 1 till the middle of the 3rd year. The 22 cases may be classified as follows :—

——	Boys.	Girls.
Late in speaking	3	—
Partial deaf mutism	—	2
Careless	10	4
Enlarged tonsils, &c.	2	1

No child was found to be tongue-tied.

The 14 children under the heading "Careless" spoke quite distinctly with care. Some had probably acquired their defect through imitation ; others spoke too fast. With regard to the 2 girls partially deaf mute, there is a family history in each case of similar defect.

Lisping.—21 boys and 13 girls, of which 76·4 per cent. were between the 5th and 8th year inclusive.

The cases may be classified thus :—

——	Boys.	Girls.
Letter S only....	11	4
S and other consonants	9	3
Other consonants only	1	6

The consonants, other than S, which gave trouble were mainly G, K and T.

Etiology and associated conditions.—4 boys and 2 girls were late in speaking (2nd to 4th years). Four boys and 1 girl had some obstruction in the upper air passage, either enlarged tonsils or enlarged tonsils and adenoids. In the case of 1 boy and 1 girl the lisp was due to the absence of the upper front teeth; 12 boys and 9 girls appeared to have no associated physical defect, a percentage of 61·7. No child was found to be tongue-tied.

The narrow arched palate was found in 4 of the lisp cases, in 2 of the indistinct cases, and not at all among the stammerers. With regard to these 6 cases, 2 were late in speaking (4th year), 1 had enlarged tonsils and 1 had defective front teeth Considering how frequently the arched narrow palate is met with among children with no speech defect, it is probable that the shape of the palate has little or nothing to do with such defect.

Cleft Palate.—The 4 cases (girls) may be referred to in some detail:—

(1) Girl, aged 6; cleft soft palate, and posterior edge of hard palate. Operation, 1920. Successful union of soft palate; an aperture about the size of a pea at centre of posterior edge of hard palate.
(2) Girl, aged 10; cleft palate and double hare-lip. Operation, 1915. Result closure; central aperture at posterior edge of hard palate about size of pea.
(3) Girl, aged 11; widely cleft hard and soft palate. Several unsuccessful operations. No hare-lip.
(4) Girl, aged 13; cleft palate and single hare-lip (left lateral). Four operations between 3rd week and 4th year. Satisfactory result.

Many infants with varieties of this deformity die from malnutrition. The mortality must be very great to account for the difference between the number of cases met with among adults and the number of cases seen as infants at the children's hospitals. That the above children are girls, and no boy with this deformity was seen in 1923, invites some inference. Possibly the mortality among the baby boys is greater than that of the baby girls, or the deformity is commoner among the latter.

With regard to speech defect in these 4 cases, the difference was a matter of degree of size and of impaired mobility of the soft palate, due to thickening, deformity or partial paresis, and its consequent failure to prevent the expulsion of air through the nose. Naturally, none of the cases had any difficulty with nasal consonants—m, n, ng; the vowel sounds were good, and words with nasal consonants gave no trouble, *e.g.*, money, on, no, none. The specially difficult consonants, owing to the soft palate's failure to shut off the nasal passages, were the explosive labials p and b, and throatal letters, k, q, hard c and g. The complication of hare-lip increased the difficulty with the explosive labials.

Since it is not the successful operation, but the subsequent training, which improves the voice, parents should have that fact impressed upon them. Of the 4 cases described above, only 1, number 4, is now speaking well, having greatly improved during the last 8 months. No real attempt appears to have been made to train cases 1 and 2. Case 3 might be possibly improved a little if fitted with an artificial velum; the speech is very defective.

Treatment of Speech Defects.

It has been pointed out above that 75·6 per cent. of the stammerers were from 9 to 14 years old inclusive; that 68·1 per cent. of the indistinct speech cases were from 7 to 9 years old inclusive, and that 76·4 per cent. of the lisping cases were from 5 to 8 years old inclusive. The significance of these percentages will be easily realised. There can be no doubt that the care taken by teachers in the infant departments of the Schools to instruct children to speak clearly accounts very largely for the relative infrequency of lisping and indistinctness of speech found among the children during the second half of their school life. The obstacles to be overcome by lip and tongue training are adequately met. With regard to the stammerers the case is very different, the great majority being in the second half of school life. These cases, slight or otherwise, if they are to be cured, require training of so special, constant and individual a character as to be quite outside the province of the Teachers at the Schools. The same must be said of the cleft palate cases, and, of course, of the partial deaf mutes.

Although no provision has been made in the Public Elementary School Area for the treatment of speech defect, so that a stammerer could be withdrawn from the School for a course of training, and few parents are in a position to secure special training for their children during the holidays, nevertheless something can be done to help the stammerer to overcome his defect, and all such cases should be brought to the notice of the School Doctor. It would be impossible within the limits of these notes to give a detailed account of the treatment of stammering; nor is it necessary. This much, however, may be said. The general health and any physical defects should be attended to. A left-handed child with stammer should not be made to use the right hand. Possibly indiscriminate attempts to convert left-handed children into right-handed children may cause stammering. It was attempted, in the case of each stammering child seen during 1923, to inspire him with confidence in his power to help himself. He was shown, in various ways, that it was quite possible for him to speak without stammering, and especially without contortions. He was given some simple instructions, according to the nature of the case, which he could practise at home for 15 minutes every day. If the interest and co-operation of the parent could be secured, so much the better. But this was not always possible, particularly among parents who take up the attitude of "Oh, he will grow out of it," or whose idea of treatment is ridicule, scolding or punishment. Most of the children were seen again from time to time as opportunity offered and improvement noted when the instructions had been regularly and properly carried out. But in many cases instructions given were not attended to or were practised irregularly and in a careless, unintelligent manner. Of course, no improvement could be hoped for in the circumstances, and none was found. The reports of Teachers as to the improvement in boys who were persevering with their self training were mostly favourable, and have been very helpful.

The badly stammering child is suffering from a defect which is mentally detrimental and physically also. However intelligent, he is badly handicapped at school and through life. It seems incredible that a defect so serious and far-reaching in its effects should ever be neglected when other defects of far less consequence receive all the treatment required. Can any one watch a badly stammering child and not believe that he is distressed in mind and body? Do those who are impatient with such a child never realise his martyrdom? Neglect to obtain skilled treatment for a child crippled in limb is regarded as almost a crime, but not for one crippled in speech. Yet of the two forms of crippling, which is the worse?

(*b*) SOME NOTES BY DR. DANIEL ON THE IMPORTANCE OF THE TEACHING OF SWIMMING AT SECONDARY SCHOOLS.

With regard to the Secondary Schools, for the medical inspection of the boys of which I am responsible, it was stated in the Report of the School Medical Officer for 1922 that "far too many boys cannot swim." During the years 1921, 1922 and 1923, every boy seen at the routine medical inspections was asked if he could swim, and the importance of learning was strongly impressed upon those who could not, and who were not physically unfit to be taught. A boy, who might be found physically unfit for swimming as a sport, and even as an exercise, is not necessarily unfit to be taught to swim. Boys whose physical condition made swimming lessons inadvisable were found to be very few indeed.

When speaking to non-swimmers and their parents about the value of swimming, "life-saving" was always insisted on as the cardinal point, and not the opportunity afforded for healthy exercise, though, of course, that was not overlooked. Curiously enough, very few seemed to realise this, as was evident from the two excuses almost invariably made. Either the boy was "not strong enough for that kind of exercise" or that "he did not like the water." The first objection was easily met by pointing out that the boy was quite strong enough to *learn* to swim if properly taught; and the second that he would dislike the water very much more if he fell in and did not know how to get out. In only one instance did a parent dispute the advantage of being able to swim, giving it as her opinion that there was no use learning, and that she didn't in the least believe in children being taught. Her reason for this singular and quite unshakeable conviction was that her husband had been a sailor all his life and hadn't been drowned, though he couldn't swim. Here was a case that certainly appeared to lend support to the opinion attributed to a famous Head Master, who is reported to have said that the more he knew the modern parent, the more he respected the modern boy.

When the swimming bath becomes part of the Secondary School equipment, as are the playing fields of to-day, to learn to swim may be recognised as of not less importance than learning to play football and cricket. The claims justly made for these and other games can, with equal justice, be made for swimming, as an exercise and as a sport, viz.: (1) Physical, the direct results of health and physique, (2) Educational, alertness, decision, concentration, control of brain over body. But football and cricket will not save a life from drowning, and the small boy who dives into deep water, fetches out his companion and loses no time in getting to work on resuscitating him might cause the captain of the football team to feel rather uncomfortable if he could not play a more distinguished part than that of a helpless looker-on.

A public swimming bath, though it cannot be regarded as a sufficient substitute for a School swimming bath, may, when conveniently situated, serve as a useful substitute if it is exclusively reserved for the school for teaching swimming at fixed times once or twice weekly. With a competent teacher the lesson for each boy need not and should not, exceed 10 minutes. It discourages a learner to get tired and cold in the water, and if he has a mechanical, unimaginative teacher, he will have the additional discouragement of making little or no progress.

One or two good swimmers on the Teaching Staff of the School can do much to create an interest in life-saving and swimming sports and help to give them the importance that is their due. Swimming has too long played Cinderella to her proud school-sisters, cricket and football.

It is encouraging to find that during the three-year period referred to above there has been a considerable increase in the number of boys who can swim, as will be seen by comparing the statistics for 1921 and 1923. The figures were compiled from the findings at the routine medical examinations of boys attending the Secondary Schools—Edmonton Latymer, Enfield Grammar and Southgate County.

TABLE A.—*All Ages.*

School.	Boys. Number examined.	Swimmers.	Non-Swimmers.	Per Cent. Swimmers.	Per Cent. non-Swimmers.
1921.					
Enfield	97	16	81	16·4	83·5
Edmonton	153	43	110	28·1	71·8
Southgate	110	45	65	40·9	59·0
	360	104	256	28·8	71·1
1923.					
Enfield	150	47	103	31·3	68·6
Edmonton	101	51	50	50·4	49·5
Southgate	93	52	41	55·9	44·0
	344	150	194	43·6	56·3

The percentage of swimmers has increased from 28·8 to 43·6, and it is satisfactory to find that this improvement largely results from the increase in the number of swimmers found in the age-groups "Entrants" and "12-years old."

Taking the "Entrants" and "12 years old" Groups together, the percentage of swimmers has increased from 11·6 in 1921 to 32·5 in 1923. The percentage for the "15-year-old" Group has increased from 48·1 to 59·4.

The facilities for learning to swim during the period under review have not increased in the districts where most of the boys attending these schools live; nor are the facilities equal, Enfield being at a disadvantage, as was pointed out in last year's report. Nevertheless, the percentage for "All Ages" (Routine Examination) at Enfield Grammar School has increased from 16·4 to 31·3.

It might be urged that the above figures prove that "swimming" is doing quite well enough without any special provision being required to make it do better. The reply is that 344 boys physically fit to swim should show a percentage of swimmers not 43·6 but 100.

Of the boys who could swim, very few indeed had a really practical knowledge of "life-saving." One boy, who showed some familiarity with the measures for rescuing a drowning person, was asked what he would do if the person was unconscious when landed; his reply was, "Run for a doctor."

That a boy should lose his life because he had never been taught to make some quite simple movements with his legs and arms when in the water is deplorable. It should be impossible.

Although no reference has been made to girls in these notes, it is certainly not because the matter concerns them less than boys. To every girl, physically fit to be taught, swimming should be taught, and life-saving also.

23. Miscellaneous.

The number of Teachers examined by the Medical Staff at the request of the Education Committee during 1923 was 7.

County and School Medical Officer.

March, 1924.

24. Statistical Tables.

Elementary Schools.

TABLE I.—*Return of Medical Inspection.*

A. *Routine Medical Inspections.*

Number of Code Group Inspections:—

Entrants	3,047
Intermediates	4,251
Leavers	4,146
TOTAL	11,444

Number of other Routine Inspections	243

B. *Other Inspections.*

Number of Special Inspections	13,736
Number of Reinspections	26,558
TOTAL	40,294

Elementary Schools.

TABLE II.

A. *Return of Defects found by Medical Inspection in the Year ended* 31*st December*, 1923.

Defect or Disease.	Routine Inspections. No. of Defects.		Special Inspections. No. of Defects.	
	Requiring treatment.	Requiring to be kept under observation, but *not* requiring treatment.	Requiring treatment.	Requiring to be kept under observation, but *not* requiring treatment.
(1)	(2)	(3)	(4)	(5)
Malnutrition	10	33	53	14
Uncleanliness. (*See* Table IV, Group V.)				
Skin—				
Ringworm—				
Scalp	9	—	340	—
Body	5	—	200	—
Scabies	8	—	213	—
Impetigo	35	1	1,650	—
Other diseases (non-tuberculous) ...	65	20	1,994	12
Eye—				
Blepharitis	67	6	320	—
Conjunctivitis	10	2	155	1
Keratitis...	1	—	2	—
Corneal opacities	—	2	5	2
Defective vision (excluding squint) ...	439	104	512	3
Squint	37	71	49	3
Other conditions	22	6	129	13

Ear—				
Defective hearing	91	76	99	7
Otitis media	45	18	569	2
Other ear diseases	45	6	199	8
Nose and throat—				
Enlarged tonsils only	147	300	180	17
Adenoids only	41	59	53	6
Enlarged tonsils and adenoids ...	185	80	194	8
Other conditions	48	32	428	15
Enlarged cervical glands (non-tuberculous)	3	65	183	58
Defective speech	16	47	111	104
Teeth—Dental diseases (*See Note*(*a*)) (*See* Table IV, Group IV)	1,036	76	624	1
Heart and circulation—				
Heart disease—				
Organic	15	47	24	21
Functional	—	139	13	25
Anæmia	95	68	92	133
Lungs—				
Bronchitis	18	33	186	14
Other non-tuberculous diseases ...	2	16	62	2
Tuberculosis—				
Pulmonary—				
Definite	—	1	9	1
Suspected	8	7	11	2
Non-pulmonary—				
Glands	1	2	5	5
Spine	—	1	—	1
Hip	—	2	3	1
Other bones and joints	—	3	7	1
Skin	2	—	3	—
Other forms	—	—	—	—

Elementary Schools.

TABLE II.—A. *Return of Defects, &c.*—continued.

Defect or Disease. (1)	Routine Inspections. No. of Defects.		Special Inspections. No. of Defects.	
	Requiring treatment. (2)	Requiring to be kept under observation, but *not* requiring treatment. (3)	Requiring treatment. (4)	Requiring to be kept under observation, but *not* requiring treatment. (5)
Nervous system—				
Epilepsy...	2	13	12	11
Chorea	2	8	36	17
Other conditions	12	116	50	40
Deformities—				
Rickets	2	88	7	—
Spinal curvature	10	33	7	14
Other forms	16	54	34	21
Other defects and diseases	137	127	3,390	211

Note (*a*).—The figures included in this space refer to the findings of the *Medical Officer* and not those resulting from dental inspection in the Schools by the School Dentist. The findings of the School Dentist are recorded in Table IV (Group IV).

Elementary Schools.

Table II—(*continued.*)

B.—Number of *Individual Children* (*see note* (*b*)) found at *Routine* Medical Inspection to require treatment (excluding uncleanliness and Dental Diseases).

Group. (1)	Number of Children. Inspected. (2)	Number of Children. Found to require treatment. (3)	Percentage of children found to require treatment. (4)
Code Groups:			
Entrants	3,047	356	1·16
Intermediates	4,251	575	13·5
Leavers	4,146	448	10·8
Total (Code Groups)	11,444	1,379	12·0
Other Routine Inspections.	243	26	10·7

Note (*b*).—No individual child is counted more than once in this part of Table II, *i.e.*, under B, even if it is found to be suffering from more than one defect.

Elementary Schools.

TABLE III.—*Return of all Exceptional Children in the Area on 31st December*, 1923.

			Boys.	Girls.	Total.
Blind (including partially blind).	(i) Suitable for training in a School or Class for the totally blind.	Attending Certified Schools or Classes for the Blind.	4	4	8
		Attending Public Elementary Schools	—	—	—
		At other Institutions	—	—	—
		At no School or Institution	—	—	—
	(ii) Suitable for training in a School or Class for the partially blind.	Attending Certified Schools or Classes for the Blind.	3	2	5
		Attending Public Elementary Schools	4	1	5
		At other Institutions	—	—	—
		At no School or Institution	—	—	—
Deaf (including deaf and dumb and partially deaf).	(i) Suitable] for training in a School or Class for the totally deaf or deaf and dumb.	Attending Certified Schools or Classes for the Deaf.	10	9	19
		Attending Public Elementary Schools	—	—	—
		At other Institutions	—	—	—
		At no School or Institution	—	—	—
	(ii) Suitable for training in a School or Class for the partially deaf.	Attending Certified Schools or Classes for the Deaf.	—	—	—
		Attending Public Elementary Schools	—	3	3
		At other Institutions	—	—	—
		At no School or Institution	—	—	—

Mentally Defective	Feeble-minded (cases not notifiable to the Local Control Authority).	Attending Certified Schools for Mentally Defective Children	35	18	53
		Attending Public Elementary Schools	28	38	66
		At other Institutions	1	—	1
		At no School or Institution	16	4	20
	Notified to the Local Control Authority *during the year*	Feeble-minded	1	1	2
		Imbeciles	4	3	7
		Idiots	5	4	9
Epileptics	Suffering from severe Epilepsy	Attending Certified Special Schools for Epileptics	1	—	1
		In Institutions other than Certified Special Schools	—	—	—
		Attending Public Elementary Schools	2	1	3
		At no School or Institution	3	5	8
	Suffering from Epilepsy which is not severe	Attending Public Elementary Schools	9	7	16
		At no School or Institution	—	1	1
Physically Defective	Infectious pulmonary and glandular tuberculosis	At Sanatoria or Sanatorium Schools approved by the Ministry of Health or the Board ...	4	6	10
		At other Institutions	—	2	2
		At no School or Institution	1	1	2
	Non-infectious but active pulmonary and glandular tuberculosis	At Sanatoria or Sanatorium Schools approved by the Ministry of Health or the Board ...	3	1	4
		At Certified Residential Open Air Schools ...	—	—	—
		At Certified Day Open Air Schools	—	—	—
		At Public Elementary Schools	—	—	—
		At other Institutions	—	—	—
		At no School or Institution	1	2	3

Elementary Schools.

Table III.—*Exceptional Children*—continued.

			Boys.	Girls.	Total.
Physically Defective —*contd.*	Delicate Children, *e.g.*, pre- or latent tuberculosis, malnutrition, debility, anæmia, &c.	At Certified Residential Open-air Schools ...	7	2	9
		At Certified Day Open-air Schools	—	—	—
		At Public Elementary Schools	13	11	24
		At other Institutions	—	—	—
		At no School or Institution	1	8	9
	Active non-pulmonary tuberculosis.	At Sanatoria or Hospital Schools approved by the Ministry of Health or the Board	7	6	13
		At Public Elementary Schools	2	1	3
		At other Institutions	2	—	2
		At no School or Institution	2	5	7
	Crippled Children (other than those with active tuberculous disease), *e.g.*, children suffering from paralysis, &c., and including those with severe heart disease.	At Certified Hospital Schools	—	—	—
		At Certified Residential Cripple Schools ...	1	1	2
		At Certified Day Cripple Schools	—	—	—
		At Public Elementary Schools (*see* note (*c*) ...	6	7	13
		At other Institutions	—	2	2
		At no School or Institution	7	11	18

Note (*c*).—This Table is a return of all children in the area for whom the Local Education Authority are responsible and who (except in the case of children suffering from epilepsy which is not severe), have been ascertained to be blind, deaf, defective or epileptic within the meaning of Part V of the Education Act, 1921.

Elementary Schools.

TABLE IV.—RETURN OF DEFECTS TREATED DURING THE YEAR ENDED 31ST DECEMBER, 1923 (*see note* (*a*)).

TREATMENT TABLE.

Group I.—Minor Ailments (excluding Uncleanliness, for which *see* Group V).

Disease or Defect. (1)	Number of defects treated, or under treatments during the year.		
	Under the Authority's Scheme. (2)	Otherwise. (3)	Total. (4)
Skin—			
Ringworm, scalp	317	32	349
,, body	203	2	205
Scabies	219	2	221
Impetigo	1,665	16	1,681
Other skin diseases ...	2,024	35	2,059
Minor Eye Defects—(External and other, but excluding cases falling in Group II)	643	15	658
Minor Ear Defects ...	908	15	923
Miscellaneous, *e.g.*, minor injuries, bruises, sores, chilblains, &c.)	3,038	79	3,117
Total	9,017	196	9,213

Note (*a*).—This Table deals with all defects treated during the year, however they were brought to the Authority's notice, *i.e.*, whether by routine inspection, special inspection, or otherwise, during the year in question or previously.

Elementary Schools.

TABLE IV—(*continued*).

Group II.—Defective Vision and Squint (excluding Minor Eye Defects treated as Minor Ailments—Group I).

Defect or Disease.	Number of Defects dealt with.			
	Under the Authority's Scheme.	Submitted to refraction by private practitioner or at hospital apart from the Authority's Scheme.	Other-wise.	Total.
(1)	(2)	(3)	(4)	(5)
Errors of refraction (including squint)	1,127	32	8	1,167
Other Defect or Disease of the Eyes excluding those (recorded in Group I)	76	13	—	89
Total	1,203	45	8	1,256

Total number of children for whom spectacles were prescribed :—

(*a*) Under the Authority's Scheme ...	879
(*b*) Otherwise	21

Total number of children who obtained or received spectacles :—

(*a*) Under the Authority's Scheme ...	860
(*b*) Otherwise	26

Elementary Schools.

TABLE IV—(*continued*).

Group III.—Treatment of Defects of Nose and Throat.

Number of Defects.				
Received Operative Treatment.			Received other Forms of Treatment. (4)	Total Number Treated. (5)
Under the Authority's Scheme in Clinic or Hospital. (1)	By Private Practitioner or Hospital, apart from the Authority's Scheme. (2)	Total. (3)		
—	76	76	648	724

Elementary Schools.

TABLE IV—*(continued)*.

Group IV.—Dental Defects.

(1) Number of Children who were—

(*a*) Inspected by the Dentist:

Routine age Groups—	
5	1,192
6	1,868
7	2,225
8	2,242
9	2,332
10	2,259
11	861
12	380
13	97
14	19
TOTAL	13,475
Specials*	2,102
GRAND TOTAL	15,577
(*b*) Found to require treatment	12,135
(*c*) Actually treated	6,029
(*d*) Re-treated during the year as a result of periodical examination†	2,714

(2) Half-days devoted to—

Inspection	324
Treatment	1,607
TOTAL	1,931

---

* The heading "Specials" in this Table relates to all children inspected by the School Dentist otherwise than in the course of routine inspection of children in one of the age groups covered by the Authority's approved scheme, namely, to children specially selected by him, or referred by medical officers, parents, teachers, etc., on account of urgency.

† All the cases entered under this head are also entered under head (*c*).

Elementary Schools.

TABLE IV—(*continued*).

Group IV.—Dental Defects—(continued).

(3) Attendances made by children for treatment	10,782
(4) Fillings—	
Permanent teeth	3,550
Temporary teeth	1,197
TOTAL ..	4,747
(5) Extractions—	
Permanent teeth	1,233
Temporary teeth	11,790
TOTAL ..	13,023
(6) Administrations of general anæsthetics for extractions	986
(7) Other operations—	
Permanent teeth	4,193
Temporary teeth	2,912
TOTAL ..	7,105

Elementary Schools.

Table IV—(*continued*).

Group V.—Uncleanliness and Verminous Conditions.

(i) Average number of visits per School made during the year by the School Nurses ...	14
(ii) Total number of examinations of children in the Schools by School Nurses	164,339
(iii) Number of individual children found unclean	10,774
(iv) Number of children cleansed under arrangements made by the Local Education Authority :—	
(*a*) *Actually cleansed by the Nurse :—*	
At the Homes	25
,, ,, Clinics	295
(*b*) *Cleansed under direct supervision of the Nurse :—*	
At the Homes	16
,, ,, Clinics	73
(v) Number of cases in which legal proceedings were taken :—	
(*a*) Under the Education Act, 1921 ...	—
(*b*) Under School Attendance By-laws ...	6

10*s*. Fine in each case.

Secondary, Day Continuation and Trade Schools.

TABLE I.—*Number of Pupils Inspected, 1st January to 31st December, 1923.*

ROUTINE MEDICAL INSPECTION.

I.—*Cases in which a full Examination has been made (see para. 4, Circular 1158, Board of Education).*

Age.	Secondary Schools.		Day Continuation and Trade Schools.	
	Boys.	Girls.	Boys.	Girls.
8	14	—	—	—
9	27	—	—	—
10	61	17	—	—
11	655	526	—	—
12	749	538	—	—
13	251	138	37	21
14	184	186	53	71
15	656	732	53	112
16	146	140	11	29
17	33	39	—	—
18	5	19	—	—
19	2	—	—	—
	2,783	2,335	154	233
Totals ...	5,118		387	

Secondary, Day Continuation and Trade Schools.

TABLE I—*continued.*

II.—*Cases in which only partial Examination has been made (see para.* 4, *Circular* 1153, *Board of Education).*

Age.	Secondary Schools.	
	Boys.	Girls.
11	2	—
12	61	22
13	—	1
16	—	3
Total	63	26

—	Special Cases.		Re-examinations (*i.e.*, Number of Pupils Re-examined).	
	Secondary Schools.	Day Continuation and Trade Schools.	Secondary Schools.	Day Continuation and Trade Schools.
Boys ...	71	—	350	—
Girls ...	77	5	949	6
Total ...	148	5	1,299	6

Secondary, Day Continuation and Trade Schools.

TABLE II.—*Return of Defects found in the course of Medical Inspection in* 1923.

Defect or Disease. (1)	Routine Inspection.				Specials.			
	Number referred for treatment. (2)		Number required to be kept under observation, but not referred for treatment. (3)		Number referred for treatment. (4)		Number required to be kept under observation, but not referred for treatment. (5)	
	*	†	*	†	*	†	*	†
Malnutrition	6	2	35	—	1	—	1	—
Uncleanliness—								
Head	3	6	—	—	—	—	—	—
Body	—	—	—	—	—	—	—	—
Skin—								
Ringworm—								
Head	1	—	—	—	—	—	—	—
Body	—	—	—	—	—	—	—	—
Scabies	—	—	—	—	—	—	—	—
Impetigo	3	—	—	—	—	—	—	—
Other diseases (non-tubercular) ...	31	9	13	—	—	—	—	—
Eye—								
Blepharitis	32	2	1	—	—	1	—	—
Conjunctivitis	4	1	—	—	—	—	—	—
Keratitis	—	—	—	—	—	—	—	—
Corneal Ulcer	—	—	—	—	—	—	—	—
Corneal Opacities	—	—	1	—	—	—	—	—
Defective vision	334	28	128	3	14	—	8	—
Squint	15	1	10	—	—	—	1	—
Other conditions	11	1	15	—	—	—	—	—

Secondary, Day Continuation and Trade Schools.

TABLE II. (*continued*).—*Return of Defects found in the course of Medical Inspection in* 1923.

Defect or Disease. (1)	Routine Inspection.				Specials.			
	Number referred for treatment. (2)		Number required to be kept under observation, but not referred for treatment. (3)		Number referred for treatment. (4)		Number required to be kept under observation, but not referred for treatment. (5)	
	*	†	*	†	*	†	*	†
Ear—								
Defective hearing	30	2	15	—	2	—	1	—
Otitis media...	6	2	5	—	3	—	1	—
Other ear diseases	13	—	2	—	—	—	—	—
Nose and throat—								
Enlarged tonsils	50	9	81	—	3	—	4	—
Adenoids	7	1	4	—	—	—	—	—
Enlarged tonsils and adenoids ...	24	3	28	—	—	—	2	—
Other conditions	27	3	12	1	2	—	—	—
Enlarged cervical glands (non-tubercular)...	14	1	51	—	—	—	—	—
Defective speech	7	1	15	—	3	—	—	—
Teeth—dental disease	731	66	39	—	8	—	—	—
Heart and circulation—								
Heart disease—								
Organic	14	—	35	2	—	—	3	—
Functional	9	1	103	10	2	—	6	—
Anæmia	65	10	57	—	1	—	2	—

Lungs—								
Bronchitis	6	—	3	—	—	—	—	—
Other non-tubercular diseases ...	3	—	5	—	—	—	—	—
Tuberculosis—								
Pulmonary—								
Definite	—	—	—	—	—	—	—	—
Suspected	2	1	1	—	—	—	—	—
Non-pulmonary—								
Glands	—	—	3	—	—	—	—	—
Spine	—	—	—	—	—	—	—	—
Hip	—	—	—	—	—	—	—	—
Other bones and joints	—	—	—	—	—	—	—	—
Skin	—	—	—	—	—	—	—	—
Other forms	—	—	—	—	—	—	—	—
Nervous system—								
Epilepsy	1	—	1	—	—	—	—	—
Chorea	—	—	5	—	—	—	1	—
Other conditions	13	3	21	—	1	3	1	—
Deformities—								
Rickets	1	—	4	—	—	—	—	—
Spinal curvature	104	6	110	1	3	—	1	—
Other forms...	139	9	98	—	2	—	—	—
Other defects and diseases	157	19	75	—	4	—	3	—
Number of individual pupils having defects which required treatment or to be kept under observation ...	...	...	...	... *2,304 †162	2,466.			

* = Secondary Schools.

† = Day Continuation and Trade Schools.

Secondary, Day Continuation and Trade Schools.

TABLE III.—*Summary Relating to Pupils Medically Inspected at the Routine Inspections during the year* 1923.

—	Secondary Schools.	Day Continuation and Trade Schools.
(1) The total number of pupils medically inspected at the Routine Inspections*	5,207	387
(2) The number of pupils in (1) suffering from—		
Malnutrition	43	2
Skin disease	78	12
Defective vision (including squint)	722	47
Eye disease	77	4
Defective hearing...	61	2
Ear disease	32	2
Nose and throat disease	355	49
Enlarged cervical glands (non-tubercular) ...	182	3
Defective speech	34	7
Dental disease	1,000	127
Heart disease—		
Organic	49	2
Functional	112	11
Anæmia	166	14
Lung disease (non-tubercular)	18	1
Tuberculosis—		
Pulmonary definite	—	—
Pulmonary suspected	3	1
Non-pulmonary	3	—
Disease of the nervous system	50	8
Deformities	681	29
Other defects and diseases	323	30
(3) The number of pupils in (1) suffering from defects (other than uncleanliness or defective clothing or footgear) who require to be kept under observation (but not referred for treatment) ...	778	15
(4) The number of pupils in (1) who were referred for treatment (excluding uncleanliness, defective clothing, &c.)	1,560	144
(5) The number of pupils in (4) who received treatment for one or more defects (excluding uncleanliness, defective clothing, &c.)	930	71

* "Specials" are not included in this Table.

Secondary, Day Continuation and Trade Schools.

Table IV.—*Treatment of Defects of Pupils during* 1923.

A.—*Treatment of Minor Ailments.*

Disease or Defect.	Number of Pupils.							
	Referred for Treatment.		Treated.					
			Under Local Education Authority's Scheme.		Otherwise.		Total.	
	*	†	*	†	*	†	*	†
Skin—								
Ringworm—								
Head	1	—	—	—	1	—	1	—
Body	—	—	—	—	—	—	—	—
Scabies....	—	—	—	—	—	—	—	—
Impetigo	3	—	—	—	3	—	3	—
Minor Injuries to Skin	3	—	—	—	—	—	—	—
Other Skin Diseases	28	9	—	—	23	8	23	8
Ear Disease	36	3	—	—	26	1	26	1
Eye Disease (External & other)	47	4	—	—	27	4	27	4
Miscellaneous	111	—	—	—	63	—	63	—
Total	229	16	—	—	143	13	143	13

* = Secondary Schools.

† = Day Continuation and Trade Schools.

Secondary, Day Continuation and Trade Schools.

TABLE IV.—B. *Treatment of Visual Defects.*

—	Number of Pupils.	
	Secondary Schools.	Day Continuation and Trade Schools.
Referred for Refraction	363	30
Submitted for Refraction—		
Under Local Education Authority's Scheme in Clinic or Hospital	—	—
By Private Practitioner or Hospital	200	13
Otherwise	18	2
Total	218	15
For whom glasses were prescribed	207	13
For whom glasses were provided	202	13
Recommended for treatment other than by glasses	13	—
Received other forms of treatment	9	—
For whom no treatment was considered necessary	9	2

Secondary, Day Continuation and Trade Schools.

TABLE IV.—*C. Treatment of Defects of Nose and Throat.*

——	Number of Pupils.	
	Secondary Schools.	Day Continuation and Trade Schools.
Referred for treatment	113	16
Received Operative Treatment—		
Under Local Education Authority's Scheme in Clinic or Hospital	—	—
By Private Practitioner or Hospital	41	—
Total	41	—
Received other forms of treatment	30	7

TABLE IV.—*F. Treatment of all other Defects.*

(*a*) The number of defects referred for treatment :—

Secondary Schools.	Day Continuation and Trade Schools.
1,207	129

(*b*) The effect of the measures taken :—

Secondary Schools.	Day Continuation and Trade Schools.
574 Treated	58 Treated

Secondary, Day Continuation and Trade Schools.

Table V.—*Summary of Treatment of Defects as shown in Table IV A, B, C and F, but excluding E and D.*

Disease or Defect.	Number of Pupils.							
	Referred for Treatment.		Treated.					
			Under Local Education Authority's Scheme.		Otherwise.		Total.	
	*	†	*	†	*	†	*	†
Minor Ailments	229	16	—	—	143	13	143	13
Visual Defects	363	30	—	—	218	15	218	15
Defects of Nose and Throat	113	16	—	—	71	7	71	7
Other Diseases	1,207	129	—	—	574	58	574	58
Total	1,912	191	—	—	1,006	93	1,006	93

* = Secondary Schools.

† = Day Continuation and Trade Schools.

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